

St. Louis County

Coverage Period: Beginning on or after 01-01-2017

Summary of Benefits and Coverage: What this Plan covers & What it Costs Coverage for: Single and family coverage | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bluecrossmnonline.com or by calling toll-free 1-866-873-5943.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	<p>\$250 medical per person In-Network Tier One \$500 medical per family In-Network Tier One \$500 medical per person In-Network Tier Two \$1,000 medical per family In-Network Tier Two \$750 medical per person Out-of-Network \$1,500 medical per family Out-of-Network</p> <p>Does not apply to preventive care services from In-Network Tier One and In-Network Tier Two providers. Does not apply to prenatal care services from In-Network Tier One and In-Network Tier Two providers. Does not apply to prescription drugs. Does not apply to well child care services from In-Network Tier One and In-Network Tier Two providers.</p>	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Your Deductible starts over on 12/24/16 and again on 1/1/18. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No, there are no other specific deductibles .	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	<p>Yes. \$750 medical per person In-Network Tier One \$1,500 medical per family In-Network Tier One \$2,500 medical per person In-Network Tier Two</p>	The out-of-pocket limit is the most you could pay during a coverage period (12/24/16 to 1/1/18) for your share of the cost of covered services. This limit helps you plan for health care expenses.

Questions: Call toll-free 1-866-873-5943 or visit us at www.bluecrossmnonline.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or by calling toll-free 1-866-873-5943.

Important Questions	Answers	Why this Matters:
	<p>\$5,000 medical per family In-Network Tier Two</p> <p>\$5,500 medical per person Out-of-Network</p> <p>\$11,000 medical per family Out-of-Network</p> <p>Medical plus Pharmacy Out-of-Pocket maximum will not exceed \$6,350 per person/\$12,700 per family per ACA guidelines</p>	
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balanced-billed charges, deductible carryover, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of preferred providers, see www.bluecrossmnonline.com or call toll-free 1-866-873-5943.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4 or 5. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

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Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		In-Network Tier One Provider	In-Network Tier Two Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Specialist visit	0% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Other practitioner office visit	0% coinsurance for Chiropractic services	30% coinsurance for Chiropractic services	50% coinsurance for Chiropractic services	_____none_____
	Preventive care/screening/immunization	No charge	No charge	0% coinsurance	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	50% coinsurance	_____none_____
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossmnonline.com .	Generic drugs	\$10.00 copay for retail drugs \$20.00 copay for mail service pharmacy drugs \$20.00 copay for retail 90daxRx pharmacy drugs	\$10.00 copay for retail drugs \$20.00 copay for mail service pharmacy drugs \$20.00 copay for retail 90daxRx pharmacy drugs	\$10.00 copay for retail drugs No coverage for mail service pharmacy drugs	No coverage for mail service pharmacy drugs from Out-of-Network providers. Cost sharing for non-preferred generic retail and mail order drugs is not displayed.
	Preferred brand drugs	\$20.00 copay for retail drugs \$40.00 copay for mail service pharmacy drugs \$40.00 copay for retail 90daxRx pharmacy drugs	\$20.00 copay for retail drugs \$40.00 copay for mail service pharmacy drugs \$40.00 copay for retail 90daxRx pharmacy drugs	\$20.00 copay for retail drugs No coverage for mail service pharmacy drugs	No coverage for mail service pharmacy drugs from Out-of-Network providers.
	Non-preferred brand drugs	\$40.00 copay for retail drugs	\$40.00 copay for retail drugs	\$40.00 copay for retail drugs	No coverage for mail service pharmacy drugs from Out-of-Network providers.

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Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		In-Network Tier One Provider	In-Network Tier Two Provider	Out-of-Network Provider	
		\$80.00 copay for mail service pharmacy drugs \$80.00 copay for retail 90dayRx pharmacy drugs	\$80.00 copay for mail service pharmacy drugs \$80.00 copay for retail 90dayRx pharmacy drugs	No coverage for mail service pharmacy drugs	
	Specialty drugs	Refer to applicable prescription drug cost sharing	Not covered	Not covered	No coverage for Specialty drugs from In-Network Tier Two and Out-of-Network providers.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	\$50.00 copay	\$50.00 copay	\$50.00 copay	_____none_____
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	_____none_____
	Urgent care	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fee	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0-10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Substance use disorder outpatient services	0-10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
If you are pregnant	Prenatal and postnatal care	No charge for prenatal care; 0% coinsurance for postnatal care	No charge for prenatal care; 30% coinsurance for postnatal care	0% coinsurance for prenatal care; 50% coinsurance for postnatal care	_____none_____

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Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		In-Network Tier One Provider	In-Network Tier Two Provider	Out-of-Network Provider	
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	50% coinsurance	Maximum benefit of \$25,000 per calendar year.
	Rehabilitation services	10% coinsurance for occupational therapy 10% coinsurance for physical therapy 10% coinsurance for speech therapy	30% coinsurance for occupational therapy 30% coinsurance for physical therapy 30% coinsurance for speech therapy	50% coinsurance for occupational therapy 50% coinsurance for physical therapy 50% coinsurance for speech therapy	_____none_____
	Habilitation services	10% coinsurance for occupational therapy 10% coinsurance for physical therapy 10% coinsurance for speech therapy	30% coinsurance for occupational therapy 30% coinsurance for physical therapy 30% coinsurance for speech therapy	50% coinsurance for occupational therapy 50% coinsurance for physical therapy 50% coinsurance for speech therapy	_____none_____
	Skilled nursing care	10% coinsurance	30% coinsurance	50% coinsurance	Maximum benefit of 180 days per calendar year.
	Durable medical equipment	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Hospice service	10% coinsurance	30% coinsurance	50% coinsurance	_____none_____
	Eye exam	No charge	No charge	0% coinsurance	_____none_____
	If your child needs dental or eye care	Glasses/Eyewear	Not covered	Not covered	Not covered
Dental check-up		Not covered	Not covered	Not covered	Services are not covered

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
<ul style="list-style-type: none">• Cosmetic surgery (except as specified in Plan benefits)• Dental Care• Long-Term Care• Routine foot care• Weight loss programs	<ul style="list-style-type: none">• Acupuncture (subject to coverage limitations)• Bariatric surgery• Chiropractic Care• Hearing aids for Children• Infertility treatment• Most non-emergency care when traveling outside the U.S.• Private-duty nursing• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information, on your rights to continue coverage, contact the plan at toll-free 1-866-873-5943. You may also contact your state insurance department, the U.S. Department of labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

You may also contact your state insurance department at:

Minnesota Department of Commerce
Attention: Consumer Concerns/Market Assurance Division
85 7th Place East Suite 500
St. Paul, MN 55101-2198

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your Claims Administrator by calling toll-free 1-866-873-5943. If you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 888-393-2789.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Statement?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Notice of Nondiscrimination Practices

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services such as qualified interpreters and information written in other languages are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
Blue Cross and Blue Shield of Minnesota and Blue Plus
M495
PO Box 64560
Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the telephone numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

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- electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
by phone at:
1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမူနာကတိကညီကိုင်နီ၊ တာကဟုန်နကိုင်တာမၤစၢကလီတဖန်န့လီၤ. ကိ: 1-866-251-6744 လၢ TTYအဂီၢ်, ကိ: 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

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Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ຮ່າວໆ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníít'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowolgo éí ná'ahoot'i'. Kojí éí béésh bee hodíílnih áqííqéqíóáqéqéíá. TTY biniiyégo éí íáájí' béésh bee hodíílnih.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

The "Patient pays" amounts assume the patient is not using funds from a Flexible Spending Account (FSA), a Health Savings Account (HSA), or an integrated Health Reimbursement Arrangement (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). Account balances may provide you funds to help cover out-of-pocket expenses.

Having a baby (normal delivery)

■ Amount owed to providers: **\$7,540**

■ Plan pays **\$6,700**

■ Patient pays **\$840**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$250
Copays	\$20
Coinsurance	\$420
Limits or exclusions	\$150
Total	\$840

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

■ Amount owed to providers: **\$5,400**

■ Plan pays **\$4,570**

■ Patient pays **\$830**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$250
Copays	\$400
Coinsurance	\$100
Limits or exclusions	\$80
Total	\$830

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not excluded.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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